STATEMENT OF CONSIDERATION RELATING TO 911 KAR 2:200
Amended after Comments

(1) A public hearing on 91 KAR 2:200 was held on May 21, 2003 at 9:00 a.m. at the Health Service Auditorium, Cabinet For Health Services Building, 275 East Main Street, Frankfort, Kentucky 40621.

(2) The following people attended this public hearing or submitted written comments:

David Vance	
Steve Shannon	KARP, Inc
Fred Dent	parent
Lisa Murphy	Lifeskills, Inc.
Carl Myers	Psychologist
Mary Simmons	
Sarah Jeffries	
Teresa Karem	Dorman Center
Mike Stickler	parent
Karen Ogle	Baptist Health Care Systems, Central Baptist Hospital
Sandra Milburn	Step One Therapy

(3) The following people from the promulgating administrative body attended this public hearing or responded to the written comments:

Trish Howard	Executive Staff Advisor, Commission for Children with Special Health Care Needs

Summary of Comments and Responses

(1) Subject Matter: Primary level evaluation
(a) Comment: Mr. Myers submitted a comment that primary level evaluations must be provided by face-to-face contact with the child and the parent. He expressed concerns that the parent is not always available to be present; therefore, a grandparent or other guardian is present. He suggests that the phrase “or guardian” be added after “parent”.
(b) Response: The federal regulation (34 CFR 303.19) defines “parent” as any person acting in the place of a parent. Kentucky is adding that definition to 911 KAR 2:100. This will allow a grandparent, or any other person acting on behalf of the parent to be present for a primary level evaluation. This regulation is not being amended as a result of this comment.

(2) Subject Matter: Primary level evaluators providing therapeutic intervention
(a) Comment: Mr. Myers and Marianne Ramsey expressed concern regarding the prohibition that primary level evaluators cannot provide therapeutic intervention to a child that they evaluated. They are concerned that there are not enough primary level evaluators or professionals in rural Kentucky, and this requirement would limit the choice the family has even more. Ms. Ramsey stated that it would make more sense to be a primary level evaluator only because it is a one-time service and less of a chance that there would be a payback. Mr. Myers also asked for clarification as to when this would start.
(b) Response: In order to decrease the potential for a conflict of interest, the administration is imposing a separation of duties in the First Steps program with this provision. However, recognizing that there is a shortage of providers in some areas of the state, we are amending the regulation to allow for exceptions to this requirement by requesting prior authorization from the CCSHCN. This provision would start with primary level evaluations performed after October 1, 2003. The regulation will be amended as a result of this comment.
(c) Comment: Ms. Ogle expressed concern about the moratorium on new providers because it has “put us in a bad situation if your primary level evaluator provider can only be that, they have to pick and choose between doing a physical therapy assessment or evaluation on those patients”.
(d) Response: See response (b). The regulation will not be amended as a result of this comment.
(e) Comment: Marianne Ramsey and Gail Herndon submitted comments in regards to an annual evaluation by someone other that the treating therapist. Ms. Ramsey states, “they could have potentially 3 different therapists their first year in the program, a primary evaluator, a treating therapist and then a different one for the annual evaluation. It is a know fact that children are more comfortable with known faces and will perform better with people that view as "safe-friends". Who would be better to do the annual evaluation than the treating therapist?! They would know how to get the child to perform to their best on the evaluation. Would it not be better for First Steps to have a formal annual evaluation form for the clinician to fill out so there is consistency in what is assessed or use the same developmental test (ie Peabody, Battelle, etc) vs. having so many different people assess the child. Also, the annual evaluation could be considered an intervention and be charged as such so as to keep expenses down and not have another expensive primary evaluation charge. Ms. Herndon commented that an annual evaluation done by another provider may not be as accurate since the child would not be familiar with that person. Most children in a new situation will not perform up to their best.
(f) Response: We appreciate both sets of comments and Ms. Ramsey’s suggestions and will consider them at the next amendment of this regulation. Due to the perception of a conflict of interest, we have imposed a separation of duties provision in this program. The regulation is not being amended as a result of this comment.

(3) Subject Matter: Therapeutic intervention reimbursement rates

(a) Comment: Mr. Dent expressed concerns regarding the across the board reduction of the reimbursement rates and how it will affect services because specialists can't afford to travel long distances. He added, "any provider cannot take a 35% cut (for group therapy) without finding significant private funding to make this go. Programs will end which means the service will no longer be available which is a very important part in my child's development but all other children's development". He also stated that instead, the sliding scale for what people can pay at the top end of the scale could be increased. Mr. Stickler also commented regarding the reimbursement rates and providers who have to travel long distances to serve children. He believes there should be some sort of compensation to the providers if they have to travel outside a certain nexus area that they usually serve.
(b) Response: The administration understands Mr. Dent's concerns regarding the rate reductions. However, due to the funding for First Steps being left at the same level as it was in 2001 by the legislature and the traditional rate of growth of this program at 20% annually, it was imperative that the administration make changes in order to continue the level of services that children were receiving. The Cabinet was able to contract with Solutions, Inc., that has completed rate and time studies on other Part C programs around the country, in order to determine if the rate structure for Kentucky's Part C program was in line with other states. A sampling of our providers was selected and they responded as to how they spent their time delivering services, paperwork, traveling time, etc. The results of that report indicated that there were several disciplines whose rates were higher than statistics indicated they should be. As a result, the rates were changed, and the First Steps program was barely able to stay within the appropriated budget for this fiscal year, which ends June 30, 2003. It will be a daunting task to contain the rate of growth again for the next fiscal year. The Interagency Coordinating Council (ICC), which is statutorily required to assist the administration in making these decisions, agrees with Mr. Dent's suggestion to increase the highest level of the family participation scale to $100. The ICC is currently reviewing options to address Mr. Stickler's comment regarding compensating providers who have to travel long distances. Any change as a result of the ICC's discussions will be addressed when this regulation is amended again. The regulation is being amended as a result of Mr. Dent's comment regarding the family share increase.
(c) Comment: Mr. Stickler expressed concerns providers have in his district regarding the reimbursement rate reductions and the paybacks associated with their monitoring visits. In addition, he expressed concerns regarding the rate reductions for co-treatment. He further stated, "there were times that I wanted my DI and my speech therapist there at the same time so that one of them can see what the other one is doing. So that they can agree on certain aspects or disagree on certain aspects of how therapy should proceed. Same thing with OT and PT. It should be the family's choice to have co-treatments".
(d) Response: The reimbursement rate reductions are necessary in order to maintain the level of services that the children enrolled in this program are receiving. The paybacks that providers are required to pay are as a result of

insufficient documentation to support their delivery of a service or as a result of being out of compliance with the regulations governing this program. The Legislative Research Commission (LRC) published a report in 1999 regarding the First Steps program, and one of its findings re that providers are not monitored sufficiently. Our increased monitoring is in response to that report. The federal Office of Special Education Programs (OSEP) also requires that the state agency monitor compliance with federal and state laws and regulations. We must report on an annual basis as to whether our providers are in compliance or not. In addition, the federal Part C funds are dependent on our compliance. In response to Mr. Stickler's concerns regarding co-treatment, the administration believes that the reduced rate for co-treatment is adequate for the level of service being delivered. The regulation will not be amended as a result of this comment.
(e) Comment: Dan Howard recommends that CCSHCN consider trending and indexing rates annually and increasing them when feasible.
(f) Response: We appreciate Mr. Howard's suggestion and will consider them if the legislature appropriates additional funding for this program in the future. The regulation is not being amended as a result of this comment.
(g) Comment: Dan Howard states "reimbursement for professionals are based upon per hour of service while service delivery is based upon number of units of service. The regulation should be consistent by using the same unit of measure for both reimbursement and service delivery or the regulation should stipulate how the conversion between the two is done."
(h) Response: The CCSHCN appreciates the comment and will amend the regulation accordingly.

(4) Subject Matter: Center-based programs
(a) Comment: Ms. Karem, Michelle Bates, and Ms. Lorri Stivers expressed concern regarding the rate reductions for center-based programs and the fact that it will seriously impact the program at the Dorman Center. Ms. Karem stated, "they offer activities that promote opportunities for children to use fine and large motor skills, opportunities for social interaction which is very important for learning and getting along in the communities. Language development with peers, enhancing cognitive development through play and adaptive opportunities such as feeding. They participate in a variety of activities that support desired outcomes identified by their families as their IFSPs. This natural environment provides opportunities for all children to be in the care of trained interventionists. They are served in an environment that does not separate them from their age-mates neighbors without developmental delays and allows modeling of age-appropriate behaviors. Attendance at center-based programs is a choice of delivery that many families find valuable. This placement speaks volumes for what these families desire for their children. It is our job to listen to them. We hope that funding is available and provided for these programs". Ms. Bates stated "as an administrator, (Principal of Southside Elementary School) I am seeing younger and younger children qualifying for special education under and Emotional Behavior Disorder. These children cannot function in a regular

classroom because of their socialization skills. Many of these students would have benefited from the early intervention of playgroup before their behaviors became so serous. These behaviors dramatically impact their academic achievement. The programs that the Dorman Center offers identify these at-risk behaviors and address them in plans that individually meet student needs.
(b) Response: We appreciate Ms. Karem's, Ms. Bates', and Ms. Stivers' comments. It has not been our intent to eliminate group therapeutic services. In fact, we encourage center-based services for those children and families that need this method of service delivery. However, we have not seen a qualitative difference in services being provided in a group setting than we've observed in an individualized one-on-one therapeutic intervention. We have seen through our monitoring efforts, that in many situations, children are being placed in group settings because that is the model of the center, not because the child needs that activity for developmental purposes. Although we know that there are many agencies that provide group services for children with disabilities at significantly lower rates, we are raising the rate for group therapeutic intervention to $32 per hour instead of the previously proposed $30. This regulation is being amended as a result of this comment.
(c) Comment: Ms. Murphy commented that this regulation discontinues the provision of multi-disciplinary group services and keeps single disciplinary group at a much lower reimbursement rate. She also expressed concerns that although the administration is not cutting group services out, the practical implication is that an agency cannot afford to provide this service at a 27-35% rate cut. Many providers in the state of Kentucky will stop providing group intervention for First Steps children. Her agency is discontinuing group services in July in anticipation of this regulation going into effect. She is concerned that many children will suffer. "Children whose behavior is too extreme to attend conventional day cares and mother's day out programs will have no socialization opportunities. Trained professionals are needed to work with these children. Day cares are understaffed. Their ratios are not sufficient to deal with the kind of issues that these children are displaying. Children with autism and social delays won't receive the socialization training from peer models that is available in the First Steps Program. Our program is integrated. We have typical children. We have children with developmental delays. We have approximately a 5/50 ratio. Another group of children who will be suffering from this will be children who live in poverty. Poor children who are already showing a significant delay in their development will be deprived of a stimulating, enriching group environment that may impact and, in some part, compensate for the poor home environment they come from. There is research in the field of child development that shows that the difference between what a child can learn by themselves and the difference in what they can learn in the presence of others and with interacting with others is very much more. That is the concept we need to embrace and help provide to all of our children in Kentucky." Mr. Dent also commented that his son has made tremendous progress in his group program. He further commented that his son's progress social wise is incredible. "You cannot get the social interacting, the skills that you are going to need to learn to survive in life further or when you get

to school age, to be able to learn in an environment where you have to have social skills. You are not going to get that in private, individual care. It has to be in a combination, which is why it is so important to keep group going." Mr. Dent also stated that he has "taken on a personal mission of looking at private funding which to date, with not doing a whole lot due to the fact of the inconsistency and not knowing where the program was going until the last couple of weeks, money will be raised and I have a mission to save this program." Laura Mize also commented that most children enrolled in her multidisciplinary groups have been rejected and dismissed by more conventional day cares and Mother's Day Out programs because of their unique needs and the understaffing of those environments. She further states that the decrease in the rate for group intervention is unmerited.
(d) Response: See response (b).
(e) Comment: Dan Howard submitted comments that falling reimbursement rates and the movement to natural settings continue to erode the feasibility of a group therapeutic intervention model. This is a concern because many families believe this model to be very effective. He recommends that the CCSHCN respond to families' desires to have these programs by establishing rates for group therapeutic intervention that maintain the programs.
(f) Response: See response (b).
(g) Comment: Suzanne and Dan Vitale and Mary Proctor submitted comments stating that social skills and interaction with other children cannot be taught or learned in an adult to child home based environment. It is essential that developmentally delayed children have the opportunity to interact with other children in a controlled group environment under the supervision of adults who are trained to encourage and teach in a playgroup environment. They requested that every consideration be given to the continuation of multi-disciplinary group intervention therapy for children with developmental delays and that the criteria for assistance not be so high as to eliminate children who are still in need of help. They added that First Steps is truly the first step for children with developmental delays in their journey through the educational system.
(h) Response: See response (b).
(i) Comment: Diana Merzweiler, the Executive Director of Down Syndrome of Louisville, Inc. submitted comments that she keeps hearing rumors that group sessions for direct intervention may not be in the future plans for First Steps. She comments further that "although our organization provides individual direct intervention, the opportunities that group sessions provide are a vital element in a child's development with Down syndrome. The visual learning style that these children embrace make for a perfect combination to be in a learning environment that allows them to learn from other children both typical and with a developmental delay. The routines they learn from being in a "preschool classroom setting" prepare these children for a smooth transition to JCPS preschool and kindergarten. Children with Down syndrome learn best by repetitive activities. Allowing these children to build group social skills at 18 months through 3 yrs old provides the necessary time to develop and retain skills. The inclusion of typical sibling in the group provides typical modeling. Our

group program goes one step further by including the parents/caregiver in the program. Each child is accompanied by an adult from their family so the activates and skills can be developed at home. In a group setting the parents are not isolated without peer support. They are given the opportunity to speak freely in regard to their child's development and know that their questions and issues will be addressed specifically for a child with Down syndrome. The group sessions allow for these children and family members to cultivate lifelong friendships and networks that will serve as lifelines when these children grow to be teens and young adults. We ask that consideration be given to the needs of the child and family when the term naturalization is used when developing a service plan for a child. Yes the child need to be seen in the home for individual sessions and adaptations in the family home but the child and the family must function in the community and group sessions is the vehicle for that transition."

(j) Response: See response (b).

(k) Comment: Julie Wright submitted comments that as soon as she found out that she was going to have a child with Downs Syndrome, her most valuable resource was the First Steps Program through the Downs Syndrome of Louisville. Her daughter is enrolled in the group program there. In addition to gross motor, fine motor, speech and cognitive skills, this group environment enhances her daughter's social skills. Thanks to the First Steps program and to the Down Syndrome of Louisville, her daughter is leading a wonderful life. She asks that these services be continued so that other children will be as lucky as her daughter and lead a "normal" and productive life.

(m) Response: See response (b).

(n) Comment: Jan Basham submitted comments that her daughter was enrolled in the group program at the Down Syndrome of Louisville. She stated that had the First Steps program not paid for her daughter's group intervention service, she could not have afforded to pay for it herself. She hope this service will go on to provide every opportunity to others that it has for her family to participate in.

(o) Response: See response (b).

(5) Subject Matter: Assistive technology

(a) Comment: Mr. Stickler commented that there should b a list of what is considered authorized assistive technology. He further stated that it appears that almost all assistive technology is being eliminated. He believes that First Steps has gone from one extreme to another in that we used to pay for everything and now we are going to pay for nothing.

(b) Response: There have no procedural changes in the way that assistive technology requests are processed or reimbursed, other than for augmentative hearing devices. Perhaps the change is due to the CCSHCN's aggressive monitoring efforts and the emphasis that only appropriate assistive technology should be provided. However, the administration agrees that there needs to be more information and guidance regarding assistive technology. The administrative regulation that governs assistive technology is 911 KAR 2:140; therefore, this administrative regulation will not be amended as a result of this comment.

(6) Subject Matter: Assessment reimbursement rates
(a) Comment: Ms. Milburn, Marsha Schofield and Laura Mize expressed concern regarding the assessment rates being reduced to the level of therapeutic intervention rates because it takes a considerable amount of time and energy on the initial assessments because it is often difficult to locate the families and schedule the assessment. The report is also lengthy and requires a lot of research in reviewing a child's diagnosis. They ask that the administration reconsider these rate reductions.
(b) Response: The administration understands their concerns regarding the assessment rates; however, the expertise required of a discipline to complete an assessment or a therapeutic intervention is the same; therefore, the administration believes that the rate should be the same. The additional time needed for an assessment is recognized; therefore, the allowed ten units have not been changed. The administration acknowledges that it is a cost-containment measure that must be taken in order to ensure this program stays within the appropriated funding. The regulation is not being amended as a result of this comment.
(c) Comment: Dan Howard submitted comments stating that the DI assessment rate is lower than the other professionals even though the DI is required to assess in all five areas of established risk while other professionals only have to assess their own area of expertise.
(d) Response: There is currently no requirement that a DI must assess in all five areas, although that is generally what occurs. Unfortunately, we are not currently in a financial position that would allow us to increase any of the proposed rates for any of the disciplines.

(7) Subject Matter: Respite
(a) Comment: Dan Howard submitted comments recommending that Section 3(5)(b) be deleted. This section prohibits families from carrying over unused respite hours to the next month. He states, "if families are empowered to manage their own respite, they will only use the respite they need when it is needed. As families have greater control over services they will use them more judiciously and may actually use less respite."
(b) Response: We appreciate Mr. Howard's comments. We believe that a families' need for respite beyond the guidelines specified in this regulation can be addressed through a request for additional units through the Payment Authorization Panel.

(8) Subject Matter: Payor of last resort
(a) Comment: Dan Howard submitted comments that although he supports the CCSHCN's attempt to use First Steps as a payor last resort, he believes that the requirements for billing insurance and Medicaid outside of First Steps places community-based service providers at a distinct disadvantage because the CCSHCN will not absorb the cost of billing insurance or Medicaid for those providers. He further commented that past payment practices allowed the

CCSHCN to reimburse agencies for services while awaiting payment from Medicaid or insurance. The proposed changes do not clarify how Medicaid and non-Medicaid providers will be paid according to the new mechanism. In addition, the proposed regulations do not address the impact the new requirements will have on timelines for submission of bills.
(b) Response: Due to the Medicaid requirements that all third party insurance be billed prior to billing Medicaid, we have no authority to change how billings occur on Medicaid eligible children. In addition, there is no change in the timelines or how we reimburse providers while awaiting reimbursement from Medicaid or insurance. These specifications are included in the CBIS billing information provided to all service providers and located on the CCSHCN website.
(c) Comment: Marie Alagia Cull submitted a comment on behalf of the Kentucky Home Health Association and Mary Jo Campbell also submitted a comment regarding the proposed requirement to bill Medicaid directly for a First Steps service prior to billing CBIS. She also asked for clarification in the proposed regulation regarding how billing is handled whether the services are traditional home health, First Steps or EPSDT.
(d) Response: CCSHCN and Department for Medicaid Services staff met concerning this issue and upon researching the payor of last resort requirements, will have determined that accessing EPSDT shall be reserved for situations where there are no other payor sources for services and prior to the involvement of the Payment Authorization Panel, in accordance with Section 4. Third party insurance and Medicaid must be billed prior to First Steps for services in any other situation in accordance with the payor of last report provisions in 34 CFR 303.124 and 303.126. The regulation will be amended for clarity as a result of this comment.
(e) Comment: Mary L. Hall submitted comments regarding her concern that Medicaid providers have to spend many hours dealing with the Medicaid Peer Review Organization, EPSDT and insurance companies, whereas an independent therapist can bill First Steps without any time delays dealing with these agencies. She further questions how an independent provider can receive the same reimbursement as a licensed Home Health Agency that has to maintain high standards to operate.
(f) Response: The CCSHCN understands Ms. Hall's frustrations regarding this issue; however, as stated in response (d) above, the federal regulations require all other payor sources be accessed prior to First Steps funds. Due to the fact that most independent providers are not allowed to enroll as a Medicaid provider, it would not be feasible for them to bill Medicaid. However, if a family chooses to use their insurance for First Steps services, the provider of therapeutic intervention services must bill the insurance prior to billing First Steps. The regulation is being amended as a result of the comment.

(9) Subject Matter: Provider moratorium
(a) Comment: Ms. Ogle expressed that people who are already First Steps providers should be able to be added to an existing provider agreement during the provider moratorium.

(b) Response: The CCSHCN cannot discriminate between independent providers and agencies. Therefore, the moratorium applies to all provider types. The "focused recruitment" of providers in areas with shortages has provided the Points of Entry and the CCSHCN with data concerning provider shortages on a county specific basis. If Ms. Ogle believes that she can fill a shortage by adding providers to her provider agreement, she should contact her Program Consultant who can provide her with direction. The regulation is not being amended as a result of the comment.
(c) Comment: Jacqueline Peterson submitted a letter introducing herself and providing information regarding her qualifications and her wishes to provide therapeutic services to the deaf community.
(d) Response: If Ms. Peterson believes that she can fill a shortage in her district, she should contact Sandra Wilson, the Program Consultant at Western Kentucky University, who can provide her with direction. The regulation is not being amended as a result of the comment.

Summary of Statement of Consideration and
Action Taken by Promulgating Administrative Body

Page 4
Section 2(2(a)
Line 19
After "person", insert "in the family's life".

Page 10
Section 2(2)(e)4.
Line 16
After "(i)", delete "Service assessment,".
Line 20
After "(i)", delete "Service assessment,".

Page 11
Section 2(2)(e)6.
Line 13
After "(i)", delete "Service assessment,".
Line 18
After "(i)", delete "Service assessment,".

Page 12
Section 2(2)(e)8.
Line 13
After "(i)", delete "Service assessment,".
Line 17
After "(i)", delete "Service assessment,".

Page 14
Section 2(2)(e)12.
Line 9
After “(i)”, delete “Service assessment,”.
Line 14
After “(i)”, delete “Service assessment,”.

Page 15
Section 2(2)(e)15.
Line 18
After “(i)”, delete “Service assessment,”.
Line 23
After “(i)”, delete “Service assessment,”.

Page 16
Section 2(2)(e)17.
Line 16
After “(i)”, delete “Service assessment,”.

Line 21
After “(i)”, delete “Service assessment,”.

Page 19
Section 2(3)
Line 7
After “increments.”, insert the following:
One hour of service shall be considered four (4) units.

Section 2(3(a)
Line 9
After “documented in”, insert “staff notes in”.

Section 2(3(b)1.
Line 16
After “documented in”, insert “staff notes in”.

Page 20
Section 2(6)(a)1.
Line 16
After “direct”, delete “root”.
In lieu thereof, insert “route”.

Page 21
Section 2(7)
Line 2
After “shall be”, delete “thirty (30)”.

In lieu thereof, insert “thirty-two (32)”.

Page 24
Section 3(6)(a)
Line 6
After “limited to”, insert “the service coordinator and”

Section 3(8)
Line 14
After “(8)”, insert the following:
Unless prior authorized by the CCSHCN due to a shortage of primary level evaluators:.

Section 3(8)(b)
Line 18
After “child”, delete the first period.

Page 27
Section 5(3)(b)
Line 9
After “time”, insert “therapeutic”.

Section 5(3)(b)1.
Lines 15 through 21
After “the family.”, delete the rest of subparagraphs 1. and 2. in their entirety.

Page 28
Section 5(3)(b)3.e.
Line 9
After “poverty”, delete “and over”.
In lieu thereof, insert “to 599”.

Line 10
After “participation”, insert the following:
.
f. From 600 percent of poverty and over the payment shall be $100 per month of participation.

Section 5(3)(d)
Line 15
Delete “primary”.
In lieu thereof, insert “initial”.

Line 17

Delete the period.
In lieu thereof, insert a semi-colon.

Section 5(3)(e)
Line 22
After “hospitalization”, delete the period.
In lieu thereof, insert the following:
.
(f) Not apply to a family that receives evaluation, assessment, service coordination, or IFSP development because the developmental evaluation or assessment did not reveal a developmental delay. The service coordinator shall notify the CCSHCN financial case manager immediately if this situation exists so that the family is not assessed a family share cost; or

Section 5(3)(f)
Line 23
Delete “(f)”.
In lieu thereof, insert “(g)”.

Page 30
Section 5(5)
Line 8
After “payment of”, delete “~~fifty (50)~~”.
In lieu thereof, insert “$100”.

Section 5(6)
Line 9
After “reason,”, insert the following:
for not applying for Medicaid of KCHIP,.
Line 11
After “payment of”, delete “~~fifty (50)~~”.
In lieu thereof, insert “$100”.

Section 5(8)
Line 17
After “months, the”, delete the following:
child shall be discharged from the First Steps Program
In lieu thereof, insert the following:
family shall receive service coordination and assessment services only until discharged from the program or the family share balance is paid in full, whichever occurs first.

Page 31
Section 7
Line 16

After “after”, delete “September”.
In lie thereof, insert “October”.